



2023

HH RN Start of Care Visit

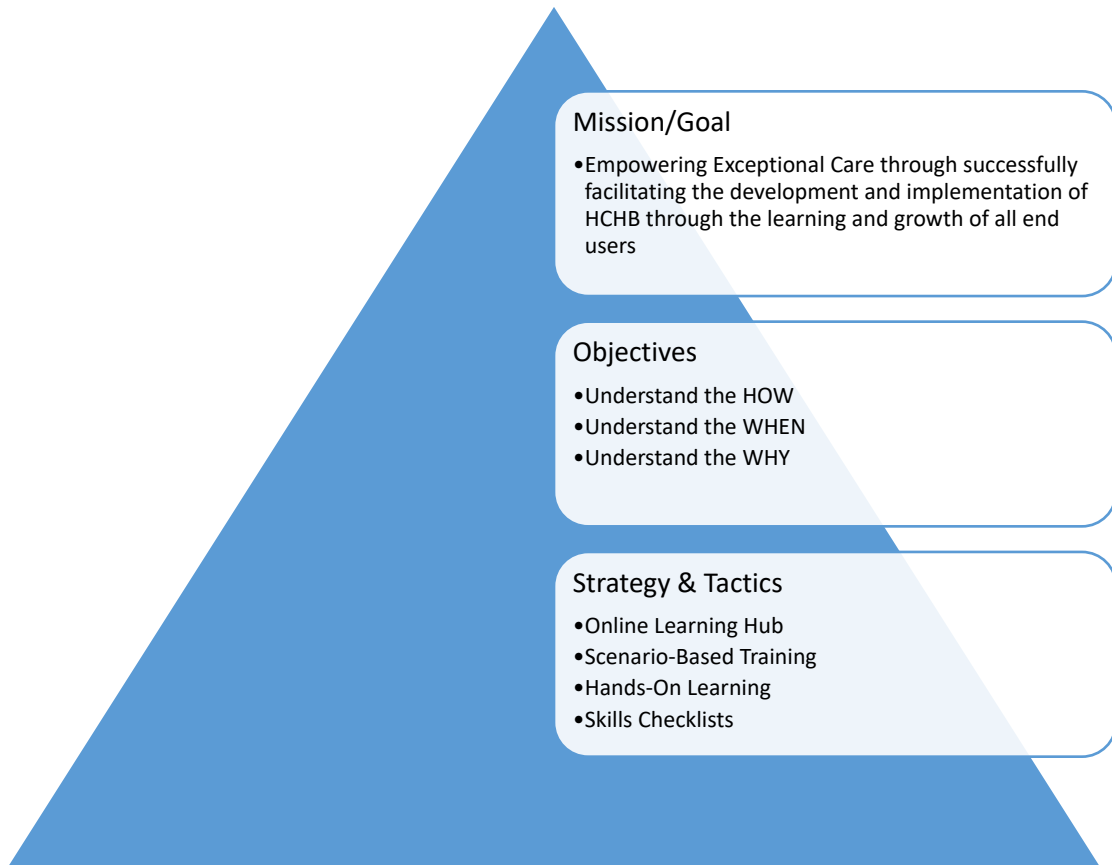
Homecare Homebase

HEMOCARE HOMEBASE, LLC

HH RN START OF CARE VISIT

OBJECTIVES OF LEARNING

Your Company and Homecare Homebase are invested in your learning experience. Therefore, it is necessary we follow a set of strategies & tactics to achieve our objectives, which ultimately lead us to our overall goal through Empowering Exceptional Care.



1. **Mission / Goal:** Successfully facilitate the development and implementation of HCHB through the learning and growth of all end users
 - 1.1. **Objective:** User to understand HOW, WHEN, & WHY in using the system
 - 1.1.1. The HCHB new user should understand the basic functionality of the PointCare application upon completion of the Online Learning Hub curriculum.

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- 1.1.2. The HCHB new user will understand how to properly begin their day and view the patient's chart before beginning a visit by the end of this course.
- 1.1.3. The HCHB new user should understand how to properly develop a 485 order that drives future visits for the patient by the end of this course.
- 1.1.4. The HCHB new user will understand how to effectively setup and document new wounds for a patient by the end of this course.

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AGENDA ITEMS

Introduction

- Who is my patient?
- How do I start my day?

15 min

Visit Actions

- Signature Forms
- Entitlement
- Demographics
- Vital Signs
- Diagnoses
- Client Medications
 - Allergies
 - Vaccination History
 - Medication Understanding
- Physical Assessment
- Pathways
- Patient Goals
- Integumentary Command Center
- Client Calendar
- Interventions / Goals

180 min

INCOMPLETE YOUR VISIT

Visit Actions

- Mileage / Drive Time
- Supplies / DME
- Aide Care Plan
- Claim Codes
- Physical Assessment (continued)
- Coordination Notes

30 min

Notes

Agency Specific Note(s)?

15 min

COMPLETE YOUR VISIT

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HISTORY OF PRESENT ILLNESS

Patient is a woman being admitted for home care due to St. II Pressure Ulcer to left heel and need for wound management. Patient has past medical history significant for type 2 diabetes, hypertension, and nicotine dependence. According to patient's husband, John Smith (contact), she has exhibited no cognitive issues or functional deficits prior to this episode of care. The patient has been noted to have a good appetite and denies problems with sleeping or weight changes. She also denies any suicidal ideations and visual/auditory issues.

PATIENT CASE STUDY

ASSESSMENT AND PLAN OF CURRENT VISIT

General: *Patient is awake, alert, and oriented to person, place, and time (AAOx3) with periods of confusion. Patient states her goals are to understand how to get better and heal her wound. She also wishes she could improve her gait and walking skills.*

Vitals, Allergies, and Vaccinations:

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Temperature	99.1	Weight	220 lbs.
Respirations	20	Height	68 in.
Pulse	85	RBS	220 mg/dl
BP	160 / 100	Pain	7

Patient states she is allergic to Penicillin and Vitamin K. Patient reports she is up-to-date with her Flu and Pneumonia vaccines as of last week.

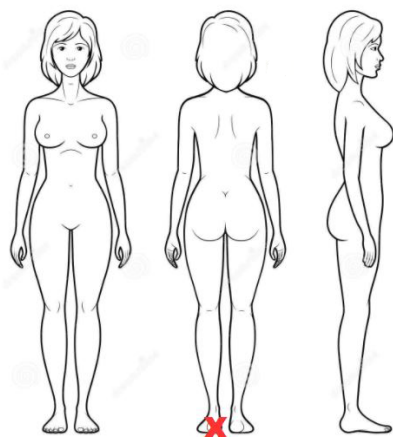
Pain: *Patient complains of pain in LLE and foot with a subjective score of 7 out of 10 on a numeric scale. She states her pain is constant. We discuss pain control measures and how to take pain medications before pain gets intolerable. We also discuss importance of offloading and elevating foot when sitting in order to decrease pain and promote healing.*

Endocrine: *Diabetes Management is discussed, including diet and nutrition related to diabetes and wound healing.*

Nutritional: *We discuss the importance of eating protein in patient's diet. Patient states fair appetite and good hydration.*

Functional: *We discuss safety ambulating and preventing falls, which can be reinforced with PT and/or OT evaluation (ordered by physician). Patient states she uses a cane for short distances and a walker for long distances, which is noted for transfers to be included in Aide Care Plan. Patient's home exhibits clear pathways, but some identified environmental/safety risks include: no handrails, no grab rails, and large rugs.*

Wound:



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Wound care ordered from physician includes: Perform/teach wound care to Stage II Pressure Ulcer on left heel – Cleanse with normal saline, apply hydrocolloid dressing, secure with tape of choice, every 5-7 days and prn soiling/de-adherence. Patient's wound measures approximately 1cm x 1cm x .5cm. Patient tolerates the wound care well with no complications. Patient does not exhibit signs and symptoms of infection at wound site. Upon our arrival, the patient had a bandage applied to wound already, and the old bandage had a small amount of serosanguinous drainage noted. We discuss signs and symptoms of infection and complications, and we instruct patient to report any S/S to nurse or physician immediately. We discuss when to seek emergency medical attention.

Aide Care Plan: Patient requires assistance of another person, extra time, and use of assistive devices to leave home safely. Patient is homebound due to pain with ambulation, SOB with minimal exertion, unsteady gait. Patient needs at least 4 ADLs (include at least 1 ambulation), 2 IADLs (include empty trash), and 1 service from another category.

SERVICES NEEDED

Patient states she would prefer not to be seen on Wednesdays due to wound clinic visits.

<input checked="" type="checkbox"/>	SKILLED NURSING	2 visits per week needed	PRN Visits?
<input checked="" type="checkbox"/>	PHYSICAL THERAPY	1 evaluation visit needed	
<input checked="" type="checkbox"/>	OCCUPATIONAL THERAPY	1 evaluation visit needed	
<input type="checkbox"/>	SPEECH THERAPY		
<input type="checkbox"/>	MEDICAL SOCIAL WORKER		
<input checked="" type="checkbox"/>	HOME HEALTH AIDE	2 visits per week needed	

DIAGNOSES

E11.40 TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSP
? PRESSURE ULCER OF LEFT HEEL, STAGE 2
? ESSENTIAL (PRIMARY) HYPERTENSION
F17.210 NICOTINE DEPENDENCE, CIGARETTES, UNCOMPLICATED
Z79.4 LONG TERM (CURRENT) USE OF INSULIN

MEDICATIONS

Medications are reviewed and reconciled. We discuss use and side effects of pain medications (Gabapentin and Hydrocodone).

MEDICATION	DOSAGE	AMOUNT	FREQUENCY	REASON
GABAPENTIN ORAL	300 mg	1 capsule	TID	Pain

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HYDROCODONE- ACETAMINOPHEN ORAL	10 – 325 mg	1 tablet	Every 6 hours PRN	Pain
LEVEMIR FLEXTOUCH SUBCUTANEOUS	100 units/mL (3 mL)	40 units	BID	Diabetes / Insulin
LISINOPRIL ORAL	20 mg	1 tablet	Daily	Blood Pressure
TEKTURNAL ORAL	150 mg	1 tablet	Daily	Blood Pressure
BACTRIM ORAL (ANTIBIOTIC)	800-160mg/ 5mL	1 tablet	Every 12 hours (<i>End Date: 10 days</i>)	UTI
SALINE WOUND WASH	0.9%	As Needed	As Needed	Wound

SUPPLIES

DME – CANE

DME – WHEELCHAIR

GAUZE

WOUND CARE SUPPLIES

DME – GLUCOMETER

DRESSING – HYDROCOLLOID

TAPE

WOUND CLEANSER

COORDINATION NOTES

NARRATIVE

SCHEDULER NOTIFICATION

CLINICAL

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NOTES & QUESTIONS

Helpful Hint – Our Quick Reference Guides are available from any computer or tablet via the Online Learning Hub website using your internet browser at:

<https://www.hchb-olh.com/page/resources>

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